Chapter Six – Common causes and suggested remedies

'… we need to go backwards first… so that we can set the standards for what is appropriate clinical competence up-front and we can monitor that prospectively before things go wrong, so if you like, park the ambulance at the top of the cliff, not the bottom of the cliff, we don't have that at the moment.'

Dr Wakefield
Executive Director
Patient Safety Centre

Part A – Introduction

Common problems, common causes

6.1 As I think already appears from what I have said so far, this examination of the above hospitals revealed a number of common problems, which together resulted in inadequate, even unsafe health care, in some cases with disastrous results. It is, perhaps, unsurprising, that these problems, common to a number of hospitals, also had common causes. It therefore became clear that, unless all of those causes are removed, or their effects substantially diminished, a serious risk of inadequate and unsafe health care in public hospitals will remain. Those problems, their causes, and some remedies are discussed in this chapter.

Inadequate budgets; defective allocation and administration

6.2 The first of these was an inadequate budget defectively administered. In a number of cases, for example, in Bundaberg, Hervey Bay, Townsville, Charters Towers and Rockhampton, inadequate budgets resulted either in doctors being appointed to hospitals who should never have been appointed, or in doctors being put in positions beyond their level of competence. In both kinds of cases, the decisions to appoint were made because the hospital budget did not permit the hospital to make an offer generous enough to attract an appropriate applicant; and where the applicant appointed was plainly in need of supervision, the hospital budget did not permit that supervision to be provided. In some cases, Bundaberg and Charters Towers being examples, this led to disastrous consequences; in all others there was a serious risk of harm and, in some, actual harm. At Prince Charles Hospital it resulted in unacceptable delays in urgent cardiac care. There were also serious defects in the way in which budgets were allocated and controlled. The allocation of elective surgery budgets placed too much emphasis on attaining target numbers, and too little on

patient care; and the excessive control exercised by administrators, because of budget constraints, and a culture of economic rationalism, led to poor decisions about patient care. This problem, its causes and some possible solutions are discussed in Part B.

Defective Area of Need Registration

6.3 The second was a defective system of special purpose registration for areas of need. The idea of special purpose registration for areas of need was a reasonable one. But it has been abused, rather than used. In many cases, registration was granted under s135 of the *Medical Practitioners Registration Act* when neither of its pre-requisites had been satisfied. The Minister's delegate and the Medical Board were both negligent in the performance of their respective duties under that section. Their failures also contributed to harmful consequences. These defects, their consequences, and the remedy are discussed in Part C.

No credentialing or privileging

6.4 The third was an absence of credentialing and privileging. In none of the relevant cases at Bundaberg, Hervey Bay, Townsville, Charters Towers or Rockhampton were the relevant doctors credentialed or privileged. This was astonishing for two reasons. The first was that the obligation to do so, and the manner of doing so, was clear and simple. Even though Mr Berg in Townsville, and Dr Maree in Charters Towers were appointed before the Queensland Health Guidelines came into effect in 2002, there were requirements in much the same terms before then. And the second and more important reason why this failure was astonishing was that it was so obviously vital for patient safety to have a doctor's skill and competence adequately assessed before he or she commenced work. There was no excuse for not doing it. This is discussed in Part D.

Inadequate monitoring of performance and investigating complaints; better protection for complainants

6.5 The fourth problem was a failure to monitor the performance of doctors including to record and properly investigate complaints. There were no regular meetings that effectively monitored clinical performance and no adequate recording of complaints in Bundaberg. Moreover, complaints were discouraged by management. The same was true of Hervey Bay. Nor was there any adequate investigation of complaints. To take Bundaberg as an example, there were more than 20 complaints against Dr Patel, in a little under two years, yet that fact was not apparent from the complaints records. Consequently, there was no way in which an accumulation of complaints, some very serious, could be seen to require investigation. Had there been any such system, Dr Patel's conduct would have been investigated properly long before it was. Much of this also applies to Hervey Bay. When one comes to making a complaint outside the

Hospital, the array of bodies to which a complaint can be made, and the appropriate body in any case, is confusing; and the overlap in their powers leads to delay and frustration. And finally, those who do complain need greater protection against retribution than they now have. These problems and their consequences, and some general suggestions about what should be done, are discussed in Part E.

A culture of concealment

6.6 The fifth problem was a tendency of administrators to ignore or suppress criticism. Recognition of these and other problems in the public hospital system was made very much more difficult by a culture of concealment of practices or conduct which, if brought to light, might be embarrassing to Queensland Health or the Government. This culture started at the top with successive governments misusing the *Freedom of Information Act* 1992 to enable potentially embarrassing information to be concealed from the public. Unsurprisingly, Queensland Health adopted a similar approach, and because inadequate budgets meant that there would be inadequate health care, there was quite a lot to conceal. Again unsurprisingly, the same approach was adopted by administrators in public hospitals, and this, in turn, led to threats of retribution to those who saw it as their duty to complain about inadequate health care. These problems and their solution are discussed in Part F.

Part B – A grossly inadequate budget and an inequitable method of allocation

Introduction

6.7 In his final submissions to this Commission, Dr Buckland said:

> …it is impossible to address the circumstances of the Queensland Health workforce, and, in particular the pressures under which hospital administrators were required to operate, without addressing:
>
> (a) the budget constraints on Queensland Health in general and on public hospitals in particular; and
>
> (b) the entrenched culture of financial compliance which focuses on throughput and revenue rather than outcomes for the patient and the community.[1]

I agree with those statements.

6.8 Consequently, while I have made findings and recommendations against Mr Leck and Dr Keating at Bundaberg, and Mr Allsopp and Dr Hanelt at Hervey Bay, I have borne these matters in mind in making them. These constraints also

[1] Final Submissions of Dr Stephen Buckland, p53